Gasior Declaration

Exhibit H-154-2

EXHIBIT B

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 122

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

INFORMATIONAL LETTER

TRANSMITTAL: 08 OHIP/INF-6

DIVISION: Office of Health Insurance Programs

TO: Commissioners of Social Services

DATE: September 29, 2008

SUBJECT: Family Health Plus Premium Assistance Program: Frequently Asked Questions

SUGGESTED DISTRIBUTION:
Medical Assistance Directors
Temporary Assistance Directors
Staff Development Coordinators
Legal Staff
Fair Hearing Staff

CONTACT PERSON:
Local District Liaison
Upstate: (518) 474-8887
NYC: (212) 471-4500

ATTACHMENTS: Attachment I: Family Health Plus Premium Assistance Program: Frequently Asked Questions

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
08 OHIP/ADM-1 08 MA/011			369-ee 3-a		

Is the Premium Assistance Program as good as Family Health Plus?

Comprehensive Health Care Coverage

Inpatient/outpatient health care

Physician services

Radiation therapy, chemotherapy, hemodialysis

Drug, alcohol, mental health services

Emergency ambulance services

Durable medical equipment

Prescription drugs

Lab tests, x-rays

Vision, speech and hearing services

Rehabilitative services

Hospice

Dental

You will get these benefits either through your Employer's Health Insurance or through your Medicaid benefit.

Are there additional benefits?

The Premium Assistance Program also pays for :

Your share of the Premium for your employer based insurance and

Reimburses for;

Deductibles;

Co-insurance;

Co-payments that exceed the Family Health Plus co-payment schedule.

What happens if I have to wait to join my employer's health insurance?

If you are eligible for this program, but are not yet enrolled in your employer's insurance, you may be enrolled in a Family Health Plus Managed Care Plan temporarily until your employer's insurance enrollment period allows you to sign up.

Children 18 years old and younger will also be evaluated for Medicaid or Child Health Plus while waiting to enroll in your employer's health plan.

Where can I apply?

You may apply using the Access NY Health Care application which can be printed from our website at: www.health.state.ny.us/nysdoh/fhplus/index.htm

Or call our toll free hotline at: 1-877-934-7587.

Or visit your local department of social services.

You may also apply through Facilitated Enrollers, which are available near you.

Call 1-877-934-7587 to find a Facilitated Enroller in your County, or visit: www.health.state.ny.us/nysdoh/fhplus/how_can_I_apply.htm

How do I apply?

You will need to complete an application, provide certain information on income and resources, and complete a personal interview before an eligibility determination can be made.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 08 OHIP/ADM-1

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: January 25, 2008

SUBJECT: Family Health Plus Premium Assistance Program

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Legal Staff
Audit Staff
Staff Development Coordinators

CONTACT PERSON:
Local District Liaisons
Upstate (518)474-8887 NYC (212)417-4500

ATTACHMENTS:
A. Applicant Fact Sheet
B. Employer Fact Sheet
C. Third Party Health Insurance Form
D. Plan Qualifications and Cost Effectiveness Worksheet
E. Manual Notice of Decision
F. Dear Member Letter

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
05 OMM/ADM-4 03 OMM/ADM-2 02 OMM/ADM-5 01 OMM/ADM-6 05 INF-16 93 ADM-29 02 INF-02 87 ADM-40			369-ee		GIS 07MA021 GIS 06MA026 GIS 05MA009 GIS 03MA025 GIS 03MA020 GIS 03MA019 GIS 02MA013 GIS 02MA017 GIS 02MA018 GIS 02MA019 GIS 02MA025 GIS 02MA033 GIS 01MA014

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I. Purpose

This Administrative Directive (OMM/ADM) provides direction to local departments of social services (LDSS) regarding the implementation of the Family Health Plus Premium Assistance Program (FHP-PAP).

II. Background

Chapter 58 of the Laws of 2007 amended Section 369-ee of the Social Services Law by adding a new subdivision 3-a which specifies that individuals meeting the eligibility requirements for Family Health Plus (FHPlus) cannot enroll in or must disenroll from a FHPlus insurance plan if a determination is made that the individual has access to cost-effective employer sponsored health insurance. Such individuals eligible for FHPlus with access to cost-effective employer sponsored health insurance must enroll in the employer sponsored health insurance in order to receive or continue to receive health care services under the FHPlus Program. In addition, individuals who do enroll in cost effective employer-sponsored health insurance shall have available health care services including: payment or part payment of the premium, co-insurance, any deductible amounts, and the cost sharing obligations for the individual's employer-sponsored health insurance that exceed the amount of the person's FHPlus co-payment obligations. The individual will also receive services and supplies otherwise covered by the FHPlus program, but only to the extent that such services and supplies are not covered by the person's employer sponsored health insurance.

Persons eligible for the Family Health Plus Premium Assistance Program include individuals eligible for FHPlus who have access to qualified employer sponsored health insurance that has been deemed to be cost effective. This includes uninsured parents, aged 19-64, of a child under the age of 21 with gross family income up to 150% of the federal poverty level and countable resources that do not exceed 150% of the annual Medically Needy income standard based on family size. It also includes uninsured childless adults aged 19-64 with gross household income up to 100% of the federal poverty level and countable resources that do not exceed 150% of the annual medically needy income standard based on family size.

Individuals who are eligible for employer-sponsored health coverage through Federal, State, county, municipal or school district health benefit plans are not allowed to enroll in Family Health Plus. Therefore, these individuals are not eligible to participate in the Family Health Plus Premium Assistance Program.

III. Program Implications

Eligibility determinations for this program will be completed as part of the initial application and renewal processes.

At the time of initial Medicaid application or renewal, individuals will be asked if they have access to employer sponsored health insurance (ESHI). If they answer affirmatively, the requirement to enroll in qualified, cost effective employer sponsored health insurance will be explained to the individual. The individual will be asked to provide information about the available employer sponsored health

insurance coverage. Pending a final determination regarding the ESHI, individuals otherwise eligible for Family Health Plus will be enrolled, or continue to be enrolled in a FHPlus plan. Upon obtaining information about the ESHI coverage available to the individual, the (LDSS) will make a determination as to whether the coverage is deemed both qualified and cost effective. If the ESHI coverage is not deemed both qualified and cost effective, the individual will be allowed to remain in the FHPlus plan. If the coverage is deemed qualified and cost-effective, the individual will be enrolled in the ESHI and disenrolled from the FHPlus plan at the earliest opportunity; that is, at the time the individual both meets the employer's requirements for participation in the plan and is permitted to enroll. FHP PAP enrollment delays may occur if the ESHI has an annual open enrollment period or wait time for coverage. If the available employer plan(s) changes before the employee can enroll, the LDSS may need to determine whether the plan remains qualified and cost effective. However, the individual will not be forced to disenroll from his/her FHPlus plan until he/she can enroll in the ESHI Program; for example: during an ESHI open enrollment period or after a required "waiting period".

If the individual leaves employment, is laid off, or retires; or if the employer drops coverage or changes the coverage so that it no longer meets the criteria for being both qualified and cost-effective, and the individual is found to still meet the FHPlus income and resource eligibility criteria, the individual may enroll in a FHPlus plan for coverage.

For those individuals who enroll or who are enrolled in ESHI, the FHPlus Premium Assistance program will pay the portion of the premium not paid by the employer. Payments will be made by the LDSS as arranged between the district and the payee using current premium payment methods.

The FHPlus Premium Assistance program will also pay claims for ESHI deductibles, coinsurance and co-payments following the current Medicaid rules for deductibles and co-payments, when such claims are submitted to Medicaid by Medicaid enrolled providers.

The LDSS will reimburse FHPlus Premium Assistance program enrollees for ESHI deductibles, coinsurance and co-pays paid by the enrollee to non-Medicaid enrolled providers upon the submission of proper documentation to the LDSS. Deductibles and coinsurance paid by the enrollee to non-Medicaid enrolled providers will be reimbursed in full. Co-pays paid by the enrollee to non-Medicaid enrolled providers will be reimbursed to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under Family Health Plus.

FHPlus wrap-around benefits will also be provided on a fee-for- service basis to individuals enrolled in ESHI to the extent that such benefits are provided by a FHPlus plan, but are not covered by the individual's employer sponsored health insurance coverage.

Enrollees in the FHPlus Premium Assistance program are required to use Medicaid enrolled providers for FHPlus wrap-around services. Medicaid providers will be reimbursed for provision of FHPlus benefits that are not covered by the ESHI up to the Medicaid rate of payment minus the enrollee's applicable FHPlus co-payment. Payment will be made through eMedNY using current claims and remittance processes.

- Enter the EPI code of A on screen 4 in WMS. This will result in a system-generated disenrollment from the FHP managed care plan with an effective date as of the MA coverage FROM date, which will be the first day of the month after T+14;
- Follow current procedures to enter the Third-Party health insurance information into the eMedNY Third-Party Sub-system for each recipient covered under the ESHI.
- Pay the ESHI premium each month, as determined by agreement between LDSS and the payee;
- Issue OHIP-0011 Attachment E, "Notice of Decision For Family Health Plus-Premium Assistance Program;" for the adults and an expanded eligibility notice for the children;

4. If the TPHI form is not returned:

- If FHPlus eligible, reauthorize the case for one year as a case type 24 with coverage code 34; continuing enrollment in a FHPlus managed care plan;
- Enter Anticipated Future Action code of 913 "Open enrollment month for PAP" and anticipated date of ESHI enrollment in WMS to track open enrollment period and take necessary action to follow-up with Applicant/Recipient for future eligibility and enrollment in ESHI. Open enrollment periods generally occur in November for January and April for June.
- Enter an HII (health insurance indicator) of "7" on screen 1 in WMS;
  Using the AFA codes and HII indicator as a tickler system, the district should mail to the recipient a copy of the Applicant Fact Sheet, "Family Health Plus and Family Health Plus Premium Assistance Program (FHP-PAP)" Attachment A, to explain the Premium Assistance Program and include a copy of the Third Party Health Insurance Form, Attachment C, prior to the applicable open enrollment period of November or June.

  And/or:

  Mail to the employer a copy of the FHP PAP Employer Fact Sheet Attachment B, and include a copy of the Third Party Health Insurance Form, Attachment C, prior to the applicable open enrollment period of November or June.

D. Transitions

In instances where a transition is made from a Family Health Plus managed care plan to the Family Health Plus Premium Assistance Program **OR** from the Family Health Plus Premium Assistance Program to a Family Health Plus managed care plan, the district must ensure that no gaps in coverage occur.

Therefore, if a FHPlus recipient enrolls in an ESHI and an overlap of coverage occurs, the district must reimburse the A/R for the premium directly and instruct the A/R to use the FHP coverage during the transition month. Disenrollment from FHPlus managed care must be processed as timely as possible to avoid a gap in coverage.

In situations where a client loses ESHI, the LDSS worker must end date the third-party health insurance information from the eMedNY Third-Party sub-system and continue coverage with Coverage Code 20 until the FHP managed care plan enrollment is processed.

Medicaid units need to inform managed care units of transitions to ensure timely enrollments/disenrollments and appropriate notice to health plans if necessary.

E. Payment

1. Employee Premium

Upstate Local Departments of Social Services must reimburse the amount of the employee premium for ESHI through the Benefit Issue Control System (BICS) system. Reimbursement may be made to the employer, insurance carrier, or to the employee if the premium is deducted from the employee's pay check.

Districts wishing to provide reimbursement outside the BICS system must request in writing an exception to this requirement. The request, along with a written proposal of the alternative methods the district wishes to employ, must be sent to:

New York State Department of Health
Third Party Liability Unit
99 Washington Avenue
Albany, New York 12210

2. Co-pays, Deductibles and Coinsurance

Family Health Plus Premium Assistance Program enrollees should be encouraged to use ESHI providers that are also enrolled in the Medicaid/FHPlus programs. This will allow deductibles, coinsurance and co-payments (that exceed those normally paid by FHPlus enrollees) to be paid through the eMedNY system, following Medicaid rules for payment of deductibles, coinsurance and co-pays.

For information on how Medicaid enrolled providers may submit claims for deductibles, coinsurance and co-pays, please refer to page 21 of the January 2007 Medicaid Update. Under the heading: Medicaid Recipients with Medicare Managed Care (HMO/MCO) Coverage.

In instances where a non Medicaid/FHPlus provider is used, reimbursement of co-pays, deductibles, and coinsurance will be made to the enrollee upon submission of documentation that demonstrates that the deductible and coinsurance and/or the co-pay was paid. No payment for incurred, but not paid, deductibles or co-payments will be made to the recipient. Documentation may include cancelled checks and/or billing statements from providers. Such reimbursement to the recipient must be made through the BICS system. (See number #1 above) Deductibles and coinsurance payments may be made directly to the provider by the LDSS if the district has a vendor ID for the provider and proof that the ESHI plan applied the service fee to the deductible.

U2 - FHP PAP Deductible - Deductible payments can be made using this code.

U3 - FHP Co-Pay Differential - The difference between a FHP/MA co-pay and the plan's co-pay can be made using this code.

U4 - FHP PAP Other - Other would be used to make payments under special circumstances for FHP medical services that were not provided by the plan nor by a Medicaid provider.

U5 - FHP PAP Coinsurance -Reimbursements for coinsurance can be made using this code.

U2, U3, U4 and U5 issuance will be once only. Payment schedule should be blank. Method of payment can be unrestricted or vendor as authorized. No special claiming code should be used.

Change to 3209 Printing
The TPHI will print on the last column in screen 4 that has the heading "UNIQ POP". The heading will be changed to "TPHI" at a future date. The EPI field may be added to the 3209 in the future.

B. PCP
If an adult or child is identified by being in PAP with the entry of an EPI code of "A" and has an existing PCP enrollment, a system-generated disenrollment will occur with an effective date as of the MA Coverage "From" date, which as described above will be the first day of the month after PAP.

PCP Exclusion
Updates to the eMedNY Third-Party subsystem are transmitted to WMS daily. As the individual's insurance will be entered in Third Party an update will be sent to WMS and a "Y" will be populated in the TPHI field. Individuals with a TPHI code = Y will be excluded from managed care auto-enrollment.

C. CNS

CNS notices to support the Family Health Premium Assistance Program will be developed in the future.

D. EEDSS

The EEDSS question set will be modified to collect information about employer sponsored health insurance.

E. eMedNY

Third Party Subsystem
The employer's insurance is third party insurance, and must be entered like other commercial insurance in the Third-Party Subsystem in eMedNY.

New York City

New York City systems instructions will follow separately.

VII. Schedule E

Premium, deductible, coinsurance and co-payments made on behalf of recipients under the Family health Plus Premium Assistance Program must be included in Line 18 of Schedule E.

VIII. Effective Date

The provisions of this Directive are effective January 1, 2008.

Deborah Bachrach, Deputy Commissioner
Office of Health Insurance Programs